BEHAVIORAL HEALTH ALLIANCE OF MONTANA

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Meeting to Discuss Mitigation of Proposed Cuts and Behavioral Health System Redesign

Radisson Hotel, 2301 Colonial Drive, Helena
August 22, 2017, 8:30 am to Noon

MEETING SUMMARY

Meeting purpose

- To identify potential strategies that can minimize the impact of SB 261 cuts, and that will strengthen Montana's behavioral health system into the future
- To envision a long-term process to redesign Montana's behavioral health system

Participants – Matt Kuntz, NAMI Montana; Sydney Blair, Center for Mental Health; Carter Anderson, Acadia; Bob Wigdorski, Gateway; Bre Lopuch, Winds of Change; Bryan Chalmers, Jennings Management; Geoff Birnbaum, Youth Homes; Leslie Nyman, Kalispell Regional Hospital; Jim Fitzgerald, Intermountain; Barbara Mettler, South Central Montana Regional Mental Health Center; Jim Hajny and Alexandra Schwier, Montana Peer Network; Cindy Stegar and Stacey Anderson, Montana Primary Care Association; Craig Aasved, Shodair Children's Hospital; Lenette Kosovich, Rimrock Foundation; Mike Chavers, Yellowstone Boys and Girls Ranch; Pat Noonan, AWARE; Michelle Aune, Mental Health America of Montana; Jodi Daly, Western Montana Mental Health Center; Scott Malloy, Montana Healthcare Foundation; Sheila Hogan, Marie Matthews, Zoe Barnard, Rebecca de Camara and Eric Higginbotham, Montana Department of Public Health and Human Services; Jessica Rhoades, Office of Governor Steve Bullock; Jane Smilie, Population Health Partners, LLC (meeting facilitator).

Welcome, introductions, how we got here

Jodi Daly, President, Behavioral Health Alliance of Montana (BHAM) gave a history of BHAM. She outlined the opportunity for BHAM to lead in developing short-term solutions to minimize the impact of the potential SB 261 cuts to behavioral health (BH) services and in creating a longer-term process to redesign the behavioral health system.

Potential short-term strategies (6 months) to minimize the impacts of SB 261 cuts

Rank	Strategy	Pros and cons	Votes
1	Provider involvement with rules process as it relates to specific services and Rate reduction = rule revision	+Buy-in from providers -Time +Reduce costs, increase workforce, reduce paperwork -Rule changes don't always get one's expected results	12
2	Streamline and integrate assessments and Utilize – 1 intake across continuum	+Good for clients +Will open up availability and access – maybe crisis appointments – work with ERs and primary care coordination to fill new spots → drive down cost to system ↑ access -Providers don't get paid when not creating widgets	8
3	Narrow menu to allow healthier rates for most needed and valued services	+Quality, stability -By who's evaluation?	4
3	Find an algorithm (of sorts) to determine services necessary per week/month for higher – medium – lower needs individuals to eliminate waste of resources	+Target resources to most needy +Efficiency -Logistical challenge	4
3	Reduce appointment no-shows with use of peer supports, evaluation kiosk, practice top of license		4
4	Type of crisis teams using EMTs in conjunction with centers	+Every community has EMT services, they are trained in crisis -Need the referral process to work – to a hospital or crisis bed for 2-3 day stabilization, etc.	3
4	Introduce new codes to our system, i.e., behavioral health counseling, etc.	+Allows us to bill for a service we are providing but is not reimbursable -System is not open to it as it would be something new Replace TCM with above	3
5	Facilitate peer support – lower needs clients can help each other. Peer support teams to offer clients a way to succeed	+People are very receptive to peer support -May not help bottom line	2
5	1915i waiver - re-enact for wraparound services - youth	Better discharge planning	2
5	Managed care legislation	+Away from fee for service	2

Rank	Strategy	Pros and cons	Votes
		-Scary and might fail worse	
5	Formal models/agreements between health systems in a community and Customer-based service/system (not $ based)	+Continuity of care, maximize resources, right level of care, minimize paperwork, shared metrics, shared scope of care +Better outcomes, healthier MT, people matter, less $ spent long term -Identity of organization -Change is hard, bigger change, more $ short-term	2
6	FQHC (& maybe RHCs) contract for behavioral health services to achieve FQHC & RHC rates*	+$ for essential services -Organizational bickering	1
6	Look for TCM alternatives with rates that make it possible and Identify new role of TCMs: kids/adults definitions/scope for model conversion	+We still need CM for our folks, care coordination exists in other systems +Efficiency same or ↑ outcomes -Usually requires a masters or nurse, - financially beyond our needs -No financial bridge, poor system of communication/tracking system/mechanisms	1
6	Reconsider PACT administrative rules**	+Serve more, impact higher levels -Administrative rules need changed	1
	Define universal crisis system for after hours, clearing house	+Better results, outcomes -Resistance from providers	
	FQHC's can provide integrated care for those with SUD and BH needs <u>not</u> in crisis	+Already have the system -Need more FQHC centers to expand primary care services	

*Cindy Stergar, CEO, Montana Primary Care Association, indicated at the meeting that the reference to "enhanced rates" was incorrect. Rather, she stated that FQHCs operate under a completely different payment methodology than other providers.

**This was the only strategy considered by the group to benefit clients served by one type of organization, rather than the entire system. PACT teams serve adult clients with higher levels of need that are served by community-based mental health centers.

The information in the table above was generated by meeting participants as follows:

- Participants were asked to work independently to brainstorm two potential strategies to minimize the impacts of potential SB261 cuts to behavioral health services, and along with each strategy, to offer possible pros and cons related to each.

- They were encouraged to consider whether the strategy would benefit clients served mainly by organizations like their own, or if it would benefit the entire BH system.
- Instructions were to write one idea and the pros and cons associated with each per ½ sheet of paper.
- Next participants were asked to spend 20 minutes (10 per person) talking to two people about their ideas. They were asked to get reactions to their draft ideas from colleagues who were not from organizations like their own.
- Participants then had the opportunity to post their best ideas on the wall. Each had a chance to provide clarifications to the entire group.
- Finally, each participant voted for the three strategies they thought had the most potential to minimize impact of cuts and were most doable in the short-term (6 months).

How a redesigned system might look – Becky Vaughn, Principal Consultant, DIR Consulting. Unfortunately, Becky was traveling abroad and we were unable to make to connect for this presentation. The purpose of the presentation was to highlight state, regional or local models or innovations that hold potential for a rural/frontier state like Montana. It was intended to help transition from short-term strategies to work on a longer-term system design.

How we get there: Potential steps in a system redesign process - Scott Malloy, Senior Program Officer, Montana Healthcare Foundation, presented an outline of potential steps in a behavioral health system redesign process. See the slide set attached.

Input on potential steps in a system redesign

Are there steps in a redesign process that are missing from what Scott presented? Anything to add? Anything to delete?	**What are 3-5 of the MOST critical issues that must be examined in a system redesign? (i.e., payment reform, crisis services, integration…)**
• Does the state have a plan? • No – focus on access; assure services for high end users; keep patients in their community; think "outside the box" • No – three tables responded with just "no" to the question above.	• Payment reform; crisis services • Access/gap analysis; payment reform/sustainability; integration of EMR systems that support incentives • Will to carry through; honest outcomes; integrated systems and valuation of the continuum; standardized assessments • Reimbursement – example psychiatrists; client outcomes – defined, info collected and pay for performance; quality measures • Focus on data (assessment)- more population focused – access to Medicaid and private payor data; commitment and will for group to strategize; critical issues will fall out of the data and assessment phase

Where should we look for innovations, models, system components that could be transferable to Montana?	How can stakeholder involvement be assured? Meaningful consume input? Policymaker buy-in?
• Other states; SAMSHA; Medicaid associations • Northwestern University; state of Indiana; Illinois Chapin Hall • Like states – geographic (weather); payment systems (NOA management); demographics (income, age, state budget); pilots (outcomes); programs in other places, countries - example "CST by people trained by non-licensed staff"; Denver community centers – city tax, alcohol tax, marijuana tax • Other states – Oregon; other disease management approaches	• Public comments – technology • Trust BHAM • Buy-in from DPHHS to work through the process of redesign • Coalesce the data for policymakers; consumer input - utilize SAAs, LACs; use sequential intercept mapping of systems • $, it has to make sense; goals of the system – cost, client care, balance; ask them, inform them, ask them again – the Governor and the Legislature • Excite them! Will it really happen; not an individual issue, it is a community issue – educate the public; economic – e.g., assessment on any rule change?; tangible – make it connect to what is going on - *state must be involved; *legislators – elected officials at all levels involved

Participants worked at their tables in groups to generate the information in the table above. Each group reported back to the larger group.

Department of Public Health and Human Services Director Sheila Hogan spoke to the group. She reminded the group that she and many of the others in leadership in behavioral health at the Department are new. She indicated her willingness to partner. She commented that she liked the concept she heard from Scott Malloy, to create a, "blueprint for a contemporary behavioral health system."

Next Steps – Jodi Daly, BHAM President closed the meeting providing assurance that the BHAM Board would use the information gathered at the meeting to determine next steps. The BHAM Board meeting is Tuesday, August 29. In addition, it will be provided to DPHHS Director Hogan and key state leaders.